

Douglas Quint, M.D.  
11/13/2012

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UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

JAROSLAW WASKOWSKI,  
  
Plaintiff,

-v-

Case No. 11-CV-13036  
  
Hon. Mark A. Goldsmith

STATE FARM MUTUAL AUTOMOBILE  
INSURANCE COMPANY,  
  
Defendant.

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The deposition of DOUGLAS J. QUINT, M.D.,  
Taken at 623 West Huron Street,  
Ann Arbor, Michigan,  
Commencing at 5:09 p.m.,  
Tuesday, November 13, 2012,  
Before Cheryl McDowell, CSR-2662, RPR.

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1 APPEARANCES:

2 MR. LEE ROY H. TEMROWSKI - P31967

3 Temrowski & Temrowski

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6 (586) 254-5566

7 Appearing on behalf of the Plaintiff.

8

9 MR. JAMES F. HEWSON - P27127

10 MS. DIANE L. HEWSON - P44628

11 MR. MICHAEL C. BAKOTICH - P75521

12 Hewson & Van Hellemont, P.C.

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14 Oak Park, Michigan 48237

15 (248) 968-5200

16 Appearing on behalf of the Defendant.

17

18 ALSO PRESENT: MR. MARC MYERS, VIDEO TECHNICIAN

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23	(Exhibits attached to transcript.)	
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25		

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1 Ann Arbor, Michigan  
2 Tuesday, November 13, 2012  
3 About 5:09 p.m.

4 THE VIDEO TECHNICIAN: We are now on the  
5 record. This is the videotaped deposition of Doctor  
6 Douglas Quint being taken in Ann Arbor, Michigan.  
7 Today is Tuesday, November 13th, 2012. The time is  
8 now 5:09 p.m.

9 And at this time will the attorneys please  
10 state their appearances for the record and can the  
11 court reporter please swear in the doctor.

12 MR. TEMROWSKI: Lee Temrowski appearing on  
13 behalf of the plaintiff, Mr. Waskowski.

14 MR. HEWSON: James Hewson appearing on  
15 behalf of State Farm.

16

17 DOUGLAS J. QUINT, M.D.,  
18 having first been duly sworn, was examined and testified  
19 on his oath as follows:

20 MR. HEWSON: The record should reflect that  
21 this is the day and date set for the taking of the  
22 de bene esse deposition of Doctor Douglas Quint  
23 pursuant to notice and pursuant to the Federal Rules  
24 of Civil Procedure for all purposes set forth  
25 thereunder.

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1                   The deposition is taken specifically in  
2           lieu of Doctor Quint's live appearance at the time of  
3           trial of this matter.

4   EXAMINATION BY MR. HEWSON:

5   Q.   Good afternoon, sir.

6   A.   Hi.

7   Q.   For the record and for the jury, would you identify  
8           yourself and give us your professional address.

9   A.   I am Douglas Quint, Q-U-I-N-T, and I work at the  
10          University of Michigan Medical Center in Ann Arbor,  
11          Michigan.

12   Q.   And what do you do there?

13   A.   I am a neuroradiologist.

14   Q.   What is a neuroradiologist?

15   A.   A neuroradiologist fits into the general category of  
16          radiology, of imaging. As a neuroradiologist, though,  
17          I only do brain and spine imaging. I do not review  
18          chest x-rays, knee x-rays, ultrasounds in pregnant  
19          ladies. I only do brain and spine imaging.

20   Q.   And when you say imaging, what kinds of tests does  
21          that include?

22   A.   That includes, there's lots of different ways one can  
23          image the spine, the brain, the head, the central  
24          nervous system. One can use x-rays, one can use CAT  
25          scans, one can use MRI scans.

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1                   One can do procedures. You can put  
2 catheters inside people and do angiograms of the  
3 brain. One can put needles in the spine and do what  
4 are called myelograms of the spine.

5                   I also do biopsies of discs, I do biopsies  
6 of the spine, I'll do biopsies of abnormalities deep  
7 in the face or deep in the neck, also. But I'm  
8 limited to head, brain, spine, and their contents.

9   Q.   And, sir, do you hold any positions at the University  
10 of Michigan Medical School?

11   A.   I am a tenured professor of neuroradiology and  
12 magnetic resonance imaging.

13   Q.   And what does it mean to be a tenured professor?

14   A.   Well, it means that I've done a bunch of academic  
15 things over the years including writing papers and  
16 doing presentations all over the region, the country,  
17 and I do a lot of teaching. I've been at the  
18 University for the past twenty-five years.

19   Q.   Are you board certified in your specialty?

20   A.   I am.

21   Q.   How long have you been board certified as a  
22 neuroradiologist?

23   A.   I've been, well, I've been board certified as a  
24 radiologist since I completed training in 1986.

25                   In my subspecialty field, neuroradiology,

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1 they don't call it a board certification. They call  
2 it a subspecialty certification, a certificate of  
3 added qualification, which after two years of  
4 additional training in neuroradiology, I got in 1988.

5 And I have, even though I'm grandfathered  
6 in, I have recertified and done what's called a  
7 maintenance of certification in neuroradiology both in  
8 1995 and 2005, and I will be coming up again in 2015.

9 Q. Okay. You brought with you a copy of your curriculum  
10 vitae today, did you not?

11 A. I did.

12 Q. Can you pull that out of your file for me?

13 Do you have a problem if I use this as an  
14 exhibit, sir?

15 A. No.

16 Q. Very good. I'm going to mark this as Exhibit 1 and  
17 show it to my brother counsel.

18 Is that curriculum vitae up to date as of  
19 today's date which is November the 14th, two  
20 thousand -- it's not. It's November 13th, thank you,  
21 Miss Court Reporter, November 13th, 2012.

22 A. Yes. I believe I printed it out over the -- in the  
23 past couple of days.

24 Q. And it includes all your professional accomplishments,  
25 publications, and appointments, am I correct?

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1 A. That is correct.

2 Q. Do you do neuroradiology for any other hospital  
3 besides U of M Hospital?

4 A. I also do some at the VA Hospital in Ann Arbor, not as  
5 much as I used to as we now have dedicated  
6 neuroradiologists over there, but I still consult from  
7 time to time.

8 Q. And please forgive me if I've asked this already.  
9 What is your position at the hospital, at U of M  
10 Hospital? I know the medical school is your tenured  
11 professorship, but --

12 A. It's really the same thing. I practice at the  
13 hospital. I do all my work at the University of  
14 Michigan Medical Center.

15 Q. Can you tell me how much of your practice is taken up  
16 with doing record reviews in cases such as this?

17 A. Of all my time, five percent maybe.

18 Q. And you have reviewed other files for my office that  
19 are in litigation, is that correct?

20 A. I have reviewed other files. I don't know the status  
21 of them with respect to litigation, but, yes, I have  
22 reviewed other cases.

23 Q. Can you tell the jury approximately how many times  
24 you've reviewed files?

25 A. I would guess eight or nine, less than a dozen.



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- 1 Q. What were you asked to do in connection with  
2 Mr. Waskowski's case?
- 3 A. I was asked to review various imaging studies of the  
4 brain and spine. All the imaging studies were  
5 obtained between January 4th, 2010 and March 24th,  
6 2011 and review them with special attention to whether  
7 I could identify anything that would be due to a  
8 traumatic event.
- 9 Q. Now, did you have a chance to look at films or did you  
10 simply look at the reports that were generated by  
11 other radiologists?
- 12 A. We don't actually have films anymore.
- 13 Q. I apologize.
- 14 A. Everything's on disc and computers and is electronic,  
15 but I have reviewed all the real images on this  
16 patient. I've also reviewed the reports, but I have  
17 looked at all the imaging.
- 18 Q. And what set of images did you look at first in  
19 connection with this case?
- 20 A. I started with the January 4th, 2010 plain x-rays, the  
21 radiographs of the cervical spine, the neck part of  
22 the spine, and of the lower back, the lumbosacral  
23 spine.
- 24 Q. The word plain in connection with x-rays, what does  
25 play x-ray mean?

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1 A. Plain x-ray is what people typically think about when  
2 you have an x-ray. That's you think about a chest  
3 x-ray, the bones, the ribs you see are nice and white,  
4 the lungs are nice and dark, but it's the type of  
5 imaging study that's been done for over a hundred  
6 years. It's called a regular x-ray or a plain film or  
7 a radiograph. It's not one of the fancier new  
8 techniques like MRI or CAT scanning.

9 Q. What, if anything, did you find significant in  
10 Mr. Waskowski's case upon your review of the plain  
11 x-rays?

12 A. The plain radiographs, the plain x-rays of the neck,  
13 the cervical spine, showed some degenerative changes,  
14 chronic degenerative changes, things which were  
15 probably months, well, probably years old involving  
16 the mid cervical spine, mid to lower cervical spine  
17 between the fourth and fifth bones in the cervical  
18 spine, narrowing the neural foramina. So degenerative  
19 changes narrowing the neural foramina on both sides of  
20 the neck bilaterally, a little more on the left than  
21 on the right.

22 Q. Can you tell me, how do you identify them as  
23 degenerative changes?

24 A. There's a certain pattern and a certain location that  
25 you expect to see things when you have degenerative

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1 changes. And, unfortunately, we all get them as we  
2 age, and there's typical locations that you get them.

3 Q. The narrowing -- I'm sorry. The degenerative changes  
4 you identified at C4 and C5, are those in the typical  
5 place that you expect them?

6 A. That's a common place to get them, and it's not at C4  
7 and C5. It's actually between C4 and C5. So the  
8 actual terminology people will use is C for cervical,  
9 meaning the neck, C4, slash, 5.

10 So at the C4-5 level, there are  
11 degenerative changes, narrowing, neural foramina,  
12 holes in the side of the spine where nerves leave the  
13 spine.

14 Q. Were there any other significant findings in the first  
15 set of plain x-rays that you reviewed?

16 A. No.

17 Q. Were you able to identify any traumatic process in the  
18 plain x-rays of the cervical spine?

19 A. No. I looked for fractures which would be the most  
20 direct evidence that you could have of a traumatic  
21 injury, but there's also secondary findings. If you  
22 break a bone or tear a ligament or soft tissue in the  
23 neck, in the spine, you're going to get swelling of  
24 soft tissues which can last for weeks.

25 And there was no -- none of those findings.

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1 So there was no indirect evidence for a recent injury  
2 to the spine.

3 Q. Thank you. What did you look at chronologically after  
4 the plain x-rays of January the 4th, 2010?

5 A. Well, staying on January 4th, I tried to work through  
6 these in chronologic order. January 4th, 2010 there  
7 were also plain x-rays of the lower back, of the  
8 lumbosacral spine.

9 Q. And what, if anything, did you find in your review of  
10 those x-rays?

11 A. Not much, that, remember, plain x-rays are not very  
12 good for looking at discs or looking at nerves or the  
13 spinal cord. It's really good for looking at bones.

14 Really the only finding that I saw was some  
15 narrowing of the distance between the L5, the fifth  
16 lumbar vertebra, and the top of the sacrum, that  
17 basically where a disc would be, even though we can't  
18 see the disc on a regular x-ray, there is some loss of  
19 the height of that disc. So that's indirect evidence  
20 for degenerative change at the most common level in  
21 the lumbar spine to develop such changes.

22 Q. What, if any, evidence did you find of trauma in the  
23 plain x-rays of the lumbar spine?

24 A. Again, I didn't see any direct or indirect evidence  
25 for a recent traumatic event, no fracture and no soft

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1 tissue abnormalities, swelling that I might see after  
2 a traumatic event.

3 Q. Did you have any other films? Or I say films. Please  
4 excuse me. Any other imaging for January the 4th,  
5 2010 that you reviewed?

6 A. No.

7 Q. What was the next date of the imaging that you  
8 reviewed?

9 A. On March 18th of 2010, so about three months after the  
10 December trauma, there's a cervical spine and neck  
11 MRI.

12 Now, an MRI is a much better test for  
13 looking for everything except maybe an acute fracture.  
14 So we're three months out from the injury, so this is  
15 a good test to look for things like herniated discs or  
16 to look at other abnormalities like degenerative  
17 changes to see if they're pushing on important  
18 structures, in particular, the spinal cord or nerves.

19 Q. And in reviewing the cervical spine MRI of March the  
20 18th, 2010, what findings did you I hate to say come  
21 up with. What findings did you determine when you  
22 looked at those images?

23 A. Well, there's multiple findings on the cervical spine  
24 MRI, but, again, this is a good test for finding lots  
25 of soft tissue changes.

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1                   We saw evidence for degenerative -- I saw  
2                   evidence for degenerative changes at multiple cervical  
3                   spinal levels. Between the third and fourth cervical  
4                   vertebra there's a disc. This disc was bulging.  
5                   There was no focal abnormality of that disc. Between  
6                   the C4 and the C5 levels, there was a shallow  
7                   posterior extension of disc, a little bit pretty much  
8                   straight backwards but also a little bit off to the  
9                   right, which did narrow the spinal canal, and I would  
10                  call mild to moderate narrowing of the spinal canal at  
11                  the C4-5 level.

12                  Also at this level, we saw narrowing of the  
13                  neural foramina where the nerves go out, and that  
14                  finding correlates with the degenerative changes we  
15                  saw on the regular x-rays that we've already talked  
16                  about, the ones from January 4th. So these findings,  
17                  again, are all consistent with chronic degenerative  
18                  changes.

19                  At the C5-6 level, so this is the next  
20                  level down between the fifth and sixth cervical  
21                  vertebra, there was another posterior, more central  
22                  posterior bulging of disc material, again, causing a  
23                  little bit of narrowing of the spinal canal, some mild  
24                  central spinal stenosis, but this one's not going off  
25                  to the sides, so it's not encroaching on the neural

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1       foramina. It's not narrowing where the nerves leave  
2       the spinal canal.

3               I should mention both at this level between  
4       five and six and at the above level, the four and five  
5       level, that while there are these disc changes, they  
6       do not extend up to the spinal cord which is a  
7       critical thing to mention.

8    Q.   Why is that a critical thing to mention?

9    A.   Because if something is pushing on the spinal cord,  
10       one risks the -- all sorts of damage occurring over  
11       time. Even if it takes years and years to develop, if  
12       you see narrowing of the spinal canal with  
13       encroachment on the spinal cord, this may be something  
14       somebody needs to do something about. People are not  
15       just treated for acute abnormalities.

16               To finish our journey down the spine, the  
17       next level down the spine between C6 and C7, between  
18       the sixth and seventh bones of the neck part of the  
19       spine, again, we see a bulging disc which does not  
20       significantly narrow the spine and does not narrow the  
21       neural foramina, the areas where the nerves leave the  
22       spinal canal.

23   Q.   What, if any, findings were you able to determine  
24       relative to trauma after reviewing those images and  
25       the MRI?

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1 A. There was no evidence for a fracture of a vertebra,  
2 and sometimes after a fracture, you will see the loss  
3 of height of the fractured vertebra. You may even see  
4 some lingering edema, some swelling inside the bone.  
5 You may see some swelling of the soft tissues right  
6 next to the spine, and the MR is exquisitely sensitive  
7 to that.

8 Now, admittedly, we're three to four months  
9 out from the traumatic event, so you may not have as  
10 much soft tissue swelling as you might have seen if  
11 the scanning had been done closer to the time of a  
12 trauma and there had been traumatic changes. But I  
13 don't see any direct or indirect evidence for trauma  
14 occurring in the past three months.

15 Q. Now, when I was looking at the reports, there was a  
16 comment that I had read that indicated there may have  
17 been effacement of the ventral subarachnoid space  
18 without cord compression.

19 Can you help me translate that? When we're  
20 talking about effacement, what does that mean?

21 A. Effacement means that something you usually see you  
22 don't see anymore, that if something is pushing on  
23 something else, you may efface that surface because  
24 something is pushing on it.

25 And in the terms of the spine, of the neck



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1 part of the spine, it's interesting anatomy. What you  
2 have is your spinal cord which is a thick structure  
3 about a third, third of an inch in diameter, tubular  
4 structure, and that sits in a fluid space, sits in a  
5 tube of fluid, so there's fluid all the way around it.  
6 So you have a spinal cord, you've got fluid around it,  
7 and then around that fluid space, you have the bones  
8 of the spine to protect that fluid and to protect the  
9 spinal cord.

10 What can happen is when a disc bulges, it  
11 can push on that fluid space and narrow that fluid  
12 space, but as I was saying before, that's okay.  
13 Effacement of the fluid space is fine, but you don't  
14 want that disc or degenerative change to be pushing on  
15 the spinal cord.

16 There's a difference. You've got fluid  
17 which is the shock absorber for the spinal cord  
18 surrounding the spinal cord, and it's okay to narrow  
19 that fluid. It is not okay to completely compress it  
20 because then you're going to start compressing the  
21 spinal cord.

22 Q. Can you have effacement of the ventral subarachnoid  
23 space without cord compression?

24 A. Yes.

25 Q. Can you tell me what the ventral subarachnoid space

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1 would be?

2 A. Well, you've got this fluid space which surrounds the  
3 spinal cord. Now, since it surrounds the spinal cord,  
4 that means some of the fluid is in front of the spinal  
5 cord, that another word for in front of is ventral.  
6 You've got fluid behind the spinal cord. We might  
7 call that dorsal. You've got fluid on both sides of  
8 the spinal cord.

9 So if we say there's effacement of the  
10 ventral fluid, that just means something has narrowed  
11 that fluid space in front of the spinal cord, but if  
12 you still have fluid on all the other sides, the  
13 spinal cord still has plenty of room. And nobody  
14 should be doing anything about a spinal canal where  
15 there's still fluid surrounding any part of the spinal  
16 cord.

17 Q. Were there lumbar images from the 18th of March 2010?

18 A. No.

19 Q. What was the next set of images that you looked at in  
20 connection with this case?

21 A. The next set of images I looked at were from April  
22 15th of 2010, and they were another MRI scan but this  
23 time of the lower back, of the lumbosacral spine.

24 Q. And what, if any, findings did you have relative to  
25 those images?

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1 A. On that study, most of the study is flat-out normal,  
2 but at the two levels that most commonly develop  
3 degenerative change with time, the lowest part of the  
4 lumbar spine, there are degenerative changes.

5 Let me get specific. Between the fourth  
6 and fifth lumbar bones of the spine, the disc at that  
7 level demonstrates a bulge which is well within the  
8 range of normal actually for somebody in their forties  
9 but could also represent chronic degenerative change.

10 At the last level, the disc between the  
11 fifth lumbar vertebra and the top of the sacrum, there  
12 is a central posterior extension of disc material, two  
13 or three millimeters, maybe a tenth of an inch, which  
14 extends up to some nerves but does not push them or  
15 compress them. There is no extension of any  
16 abnormalities into the neural foramina, the areas  
17 where the nerves leave the spinal canal.

18 So the L4-5 level and the L5-S1 level which  
19 are the two levels I just described demonstrate  
20 degenerative changes which fit for chronic  
21 degenerative changes at the most common levels to  
22 develop such changes.

23 And we all develop these changes and they  
24 actually start in your late teens. So for somebody to  
25 have changes in their forties is not that unexpected.

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1                   Again, I could not see any evidence for  
2                   trauma down there.

3       Q.     And I'm sorry I hadn't asked this earlier.  
4                   Degenerative means what? What are we talking about  
5                   when you say degenerative changes?

6       A.     With time, the discs of your spine which are basically  
7                   the shock absorbers of the spine, and you've got about  
8                   thirty of them, start drying out, and they can get  
9                   little cracks and things in them and they can lose  
10                  height and they can lose their ability to protect your  
11                  spine.

12                         This is why as people get older, in their  
13                         sixties, seventies, eighties, they actually look like  
14                         they're getting shorter which they are because their  
15                         discs, these nice fluid-filled things, are being  
16                         compressed with time. That's degenerative change.

17                         As part of a bracing procedure, the bones  
18                         of the spine near these discs will start to produce  
19                         new bone to try to add more stability to the spine,  
20                         and that's the degenerative arthritis that we talk  
21                         about with respect to the spine, and, again, you see  
22                         it in the lower neck and you see it in the lower back.  
23                         These are the most common places to develop it.

24       Q.     What was the next series of images that you had looked  
25                   at?

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1 A. The last set of images was a set of five different  
2 images obtained on March 24th of 2011. These included  
3 regular x-rays, those plain radiographs, again, of the  
4 neck, the cervical spine, and the lower back, the  
5 lumbosacral spine. They also included a repeat  
6 cervical spine, neck, and lower back lumbar spine MRI.  
7 So those four studies we've already done once, we're  
8 doing them again, and then there was a head MRI which  
9 was also performed.

10 Q. Can you tell me, is there any or is there a clinical  
11 basis upon which you would recommend repeat MRIs of  
12 the same areas that you've already gotten the tests?

13 A. Well, sometimes depending on symptoms, particularly if  
14 they're getting worse, you may want to get another  
15 study.

16 Q. What kind of symptoms would you be looking for as a  
17 neuroradiologist to prescribe a second set of MRIs of  
18 the same area?

19 A. Well, as a radiologist, I don't order studies. I  
20 don't examine the patient, I don't take the history  
21 from the patient and say, you know, we should get  
22 another study.

23 Usually somebody else has made that  
24 decision, either the patient's primary care physician  
25 or internist, their family practice doctor, or if

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1       they're seeing a subspecialist, let's say a  
2       neurologist or a neurosurgeon or an orthopedic surgeon  
3       or a physical medicine doctor might say, you know,  
4       things are changing a little bit, maybe we should get  
5       repeat imaging. It's a perfectly reasonable thing to  
6       do.

7     Q.   You're looking at if change exists, that would be a  
8       reasonable basis upon which to order another set of  
9       x-rays?

10    A.   Well, if clinically you think something is changing  
11       that that would be a reasonable thing to do.

12    Q.   There were another set of plain x-rays that were done  
13       on March 24th of 2011?

14    A.   That's correct.

15    Q.   What kind, if you know, what kind of clinical  
16       indication would you have just to run another series  
17       of plain x-rays? Why would you do that, what would  
18       you expect to find?

19    A.   Well, sometimes when you have a traumatic event, that  
20       can change the dynamics of the spine, and you might  
21       cause acceleration of abnormalities. You might see  
22       acceleration of degenerative changes, for example.

23                Again, though, mostly is there a change in  
24       the symptoms, does the patient have new arm pain, does  
25       the patient have a change in the character of their

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1 neck pain. Those would be indications that I will  
2 often see on requisitions for repeat examination.

3 Q. What findings did you make relative to the plain  
4 x-rays that were taken in March of 2011?

5 A. The neck study and the lower back studies were  
6 unchanged from the plain radiographs of January 4th,  
7 2010. So the exact same things, I could bring them up  
8 on the computer, put them side by side.

9 They actually did some incremental imaging  
10 on the March 24th, 2011 study. In addition to the  
11 standard views, they also had the patient bend their  
12 neck forward and extend their neck back and had them  
13 do the same thing with their lower back, these are  
14 called flexion and extension, to see how well the  
15 patient could move their spine in the neck and in the  
16 lower back.

17 Q. What, if anything, was significant relative to the  
18 flexion and extension views in the neck and the low  
19 back on those x-rays?

20 A. There was no abnormal motion which you sometimes might  
21 see with accelerated degenerative changes or just with  
22 a dysfunctional spine. You might see some abnormal  
23 motion of the spine.

24 In this case, I did not see that.

25 Q. What, if any, findings did you make relative to that

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1 possible acceleration of degenerative changes as a  
2 result of a traumatic event relative to these plain  
3 x-rays?

4 A. I did not see any change between the January 4th, 2010  
5 and the March 24th, 2011 studies. So to answer your  
6 question, I did not see any acceleration of  
7 degenerative change.

8 Even if I'd seen a little bit, I still  
9 wouldn't have known is this the natural course of the  
10 disease. But in this case, it looks exactly the same,  
11 and that's what you expect. Degenerative changes do  
12 not progress very, very quickly. It takes years to  
13 see changes.

14 If you see, though, accelerated changes,  
15 then you worry a little bit that something else is  
16 going on.

17 Q. The March 24th, 2011 MRIs of the cervical spine, what,  
18 if any, significant findings did you make in regards  
19 to those films, those images?

20 A. Well done.

21 Q. Thank you.

22 A. Basically both of those studies are not significantly  
23 changed from the respective ones in 2010. Again, the  
24 neck study looked essentially identical to the study  
25 performed on March, March 18th, 2010 and the lower



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1 back study looked identical to what was seen on April  
2 15th.

3 There's different scanners were used, so  
4 you're allowed to have slight, slight differences but  
5 well within the range of what you see when people are  
6 scanned on different things. So there was nothing to  
7 suggest an acceleration of any process and there was  
8 no new incidental process.

9 When you scan people a year or two in  
10 between scans, people develop cancers, people develop  
11 infections, people develop other things, and,  
12 fortunately, we did not see any changes between these  
13 studies.

14 Q. Now, were there any other studies that you had a  
15 chance to interpret relative to Mr. Waskowski?

16 A. No other imaging that I have reviewed.

17 Q. Now, you mentioned that there was a head MRI.

18 A. We forgot to talk about that. I forgot to talk about  
19 that.

20 Q. That's okay.

21 A. Yeah.

22 Q. I just wanted to make sure, first of all, are they  
23 normally called head MRIs?

24 A. Yep.

25 Q. Okay.

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1 A. Some people call it brain MRI, but --

2 Q. Okay. Now, what -- I know -- strike that.

3 What, if anything, did you find in  
4 connection with the head MRI that was significant?

5 A. The head MRI is normal. I did not see anything to  
6 suggest accelerated brain volume loss. For example, I  
7 did not see anything for there having been trauma to  
8 the brain, no posttraumatic contusion, for example,  
9 which you sometimes see when people smack their head.  
10 Sometimes you get abnormal fluid collections, subdural  
11 hematomas surrounding the brain.

12 The short answer is it's normal for age,  
13 his head MRI.

14 Q. And this was more than a year after the accident had  
15 occurred?

16 A. That's correct.

17 Q. Do you know what clinical indications you would look  
18 for, if any, to order a head MRI, what are we talking  
19 about, fifteen months post accident when there hadn't  
20 been one in the past?

21 A. There's a wide range of why people get head MRI scans  
22 that if you have any sort of symptoms referable to the  
23 brain or the head, and there's a huge range of them,  
24 you might want to take a look. If you have an  
25 accident, it may take weeks to months to see the

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1 posttraumatic changes.

2 And what we look for is either a focal  
3 brain injury near the surface of the brain because the  
4 head got knocked around, or you might see generalized  
5 volume loss over time which sometimes gets put into  
6 the wastebasket term of traumatic brain injury.

7 So I don't know what the indication was for  
8 this study. It might have been headaches, it could be  
9 focal neurologic findings, but the threshold in 2012  
10 to get a head MRI is pretty low in this country. So  
11 there's a lot of borderline indications out there, and  
12 there may have been very good reasons.

13 Q. Now, did you compare the reports of the MRIs to your  
14 findings of the MRIs?

15 A. I did.

16 Q. And can you tell me how those reports compared to your  
17 findings on those MRIs?

18 A. The plain radiographs performed on January 4th, 2010  
19 and on March 24th, 2011 I agree with that they  
20 describe minimal degenerative changes at the C4-5  
21 level affecting neural foramina.

22 The first MRI scans, the ones from 2010, I  
23 don't, I do not completely agree with. The March,  
24 March 18th, 2010 cervical spine, neck MRI, for  
25 example, they describe in that report narrowing of

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1 some of these neural foramina at multiple levels, I  
2 think at 2-3, 3-4, 4-5, 5-6, and 6-7.

3 As far as I'm concerned, only one level,  
4 the C4-5 level, has narrowing of the neural foramina.  
5 And while people can argue about terminology to use, I  
6 do not see what I would call a herniated disc at the  
7 C4-5 and C5-6 level.

8 Now, I see what they were describing and I  
9 think the description is fine of what they're seeing,  
10 but I think these are changes due to the patient's  
11 underlying chronic degenerative change.

12 Q. Now, when you reviewed the report of the MRIs from  
13 March 24th, 2011, there was a different finding at  
14 C2-C3. Am I correct in that?

15 A. I'm not sure what you're asking, that in the first  
16 report they describe narrowing of the left C2-3 neural  
17 foramen, and I didn't see it on that first study and I  
18 didn't see it on the second study.

19 Q. I understand. The reports themselves are different?  
20 The films were the same?

21 A. Right.

22 Q. But the reports were different?

23 A. Correct.

24 Q. There was a comment in the March 24th, 2011 report  
25 relevant to the fact that there was no bulging at

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1 C2-C3, and those findings at least in that MRI agreed  
2 with your findings, is that correct?

3 A. That's correct.

4 Q. In your review of all of these studies, what, if any,  
5 evidence did you find -- please excuse me if I'm being  
6 redundant but I'm going to be. What, if any, evidence  
7 did you find of trauma to this, to Mr. Waskowski's  
8 spine?

9 A. I saw no evidence on any of these of the eight  
10 studies, excluding the head study, for posttraumatic  
11 changes that we could link to an event at the end of  
12 2009 involving the cervical spine or the lumbosacral  
13 spine. Everything looks like chronic degenerative  
14 change. We have no direct or indirect evidence on any  
15 of the imaging studies for a traumatic event in  
16 December 2009.

17 Q. Can you tell the jury what a bone scan is, please?

18 A. A bone scan is a test done in usually in nuclear  
19 medicine departments, and how a bone scan works is you  
20 actually inject a very small amount of radioactive  
21 material into a patient's vein, and this radioactive  
22 material will concentrate in areas where bones are not  
23 normal, where they're turning over faster than they  
24 should.

25 For example, in cancers which are chewing

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1 up bone, the bone scan is very sensitive for such, for  
2 such abnormalities. In long-distant runners,  
3 long-distance runners who have shin splints and the  
4 regular x-rays and even the MR scan can be negative,  
5 you can see small amounts of turnover of bone.

6 Degenerative changes are notorious and  
7 light up on all bone scans. So when one has  
8 degenerative changes in an unusual location, you can  
9 use a bone scan to find that.

10 Q. Will bone scans show fractures?

11 A. Bone scans are actually quite sensitive for fractures  
12 if they've been there for at least a few days. If you  
13 fracture something and get a bone scan six hours  
14 later, you will miss the fracture.

15 And, also, once a fracture is completely  
16 healed, let's say six months, a year, several years  
17 later, the bone scan won't show it anymore.

18 Q. And please forgive me for this. Were there any plain  
19 x-rays of the chest or the ribs for Mr. Waskowski?

20 A. My understanding is some were obtained, but I did not  
21 review them.

22 Q. Fair enough. Let me show what I'm going to mark as  
23 Exhibit 2.

24 And can you tell me what that appears to  
25 be, sir?

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1 A. This is a report of a bone scan performed on January  
2 25th, 2010.

3 Q. And I know I don't have the films here, but do you  
4 recognize Beaumont Hospital as being a reliable  
5 facility for performing these kinds of objective  
6 tests?

7 A. Yes.

8 Q. Can you tell the jury what, if any, findings were  
9 reported by Beaumont Hospital relative to this bone  
10 scan?

11 A. This is January 25th so this is about a month after  
12 the traumatic event, and they do not see any fractures  
13 involving the left shoulder, the ribs, or the spine  
14 which I guess is the question that was posed to them.

15 They do see a little bit of abnormal uptake  
16 of the radioactive material in the right  
17 temporomandibular joint.

18 Q. Where is that?

19 A. The temporomandibular joint is where your jaw meets  
20 your head, and you can actually feel a bump there when  
21 you open and close your mouth. That's the  
22 temporomandibular joint.

23 And since it's a moving structure, it's a  
24 place you develop arthritis, and that can be painful.  
25 So one will often see such abnormalities on a bone

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1 scan.

2 Q. I believe, and I gave my brother counsel my copies,  
3 but there's reference to mild tracer activity in the  
4 left sternoclavicular joint.

5 Could you tell me what -- first of all,  
6 where the sternoclavicular joint is, please?

7 A. The sternoclavicular joint, the clavicle is this bone  
8 right in here that everyone can feel in the upper part  
9 of their chest, and where it meets the breastbone,  
10 that junction is called the sterno, sternoclavicular,  
11 clavicle, joint, and that's these two bones right  
12 here, everybody can see, right here which you can feel  
13 as bumps.

14 And, again, since your clavicles move with  
15 respect to your breastbone, it's another area which  
16 can develop arthritis.

17 Q. Mild tracer activity, assuming that that finding is  
18 correct, what would that mean in relationship to this  
19 particular study?

20 A. It would mean arthritis in that location.

21 Q. There's also a finding at the superior aspect of the  
22 sternomanubrium and the sternal angle.

23 Could you tell me what the sterno or where  
24 the sternomanubrium is?

25 A. Actually, they're redescribing basically the same



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1 location. It's they're all right next to each other  
2 up here where the breastbone meets the clavicles. The  
3 manubrium is a part of the breastbone.

4 Q. So the mild uptake would mean the same thing in all of  
5 those three areas that are described, is that correct?

6 A. Yes.

7 Q. Very good.

8 MR. HEWSON: If I didn't move for the  
9 admission of Doctor Quint's curriculum vitae and  
10 Exhibit 2, I do now, and with that, I have no further  
11 questions. Thank you, sir.

12 EXAMINATION BY MR. TEMROWSKI:

13 Q. Doctor, my name is Lee Temrowski, and I represent the  
14 plaintiff, Mr. Waskowski, in this lawsuit.

15 A. Yes.

16 Q. You are a teacher, professor, correct?

17 A. That is correct.

18 Q. Do you actually treat individuals who have been  
19 injured in automobile accidents?

20 A. I'm not sure what you mean by treat. I evaluate  
21 imaging studies on patients who have been in  
22 accidents, and if it's been serious enough, I will  
23 literally do procedures on people.

24 Q. Well, do people who have been injured in an automobile  
25 accident come to see you for treatment for their

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1 injuries?

2 A. It depends. If you're in a serious enough accident  
3 and you tear blood vessels let's say going up to the  
4 brain, I will see you and I will see you acutely in  
5 the angiography suite. If there's concern about a  
6 fracture, I might only see your CAT scan which is  
7 obtained in the emergency department and they have me  
8 review it.

9 Q. Okay. Well, in the past year, how many face-to-face  
10 contacts have you had with patients who have been  
11 injured in an automobile accident?

12 A. Not that many. I'd say, I'd say thirty or forty. You  
13 have to be pretty seriously injured for me to come and  
14 do a procedure on you. I almost always only see your  
15 imaging study.

16 Q. And not the patient?

17 A. And not the actual patient, that's correct.

18 Q. Okay. Now, you've indicated that in this case, you  
19 actually reviewed the reports on Mr. Waskowski of the  
20 MRIs, correct?

21 A. Correct.

22 Q. And the imaging studies, correct?

23 A. That's correct.

24 Q. And do you have your file with you here today?

25 A. I do.

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1 Q. And could you pull out those reports of the MRIs?

2 A. I have all four of them, yes.

3 Q. Okay. And could I see those, please?

4 MR. TEMROWSKI: And could I have these  
5 marked as exhibits? Do you want to do it now or  
6 afterwards?

7 MR. HEWSON: It doesn't make any  
8 difference. Let's go off the record.

9 MR. TEMROWSKI: Why don't you go off the  
10 record and let's just have these marked, okay?

11 THE VIDEO TECHNICIAN: Going off the record  
12 at 5:51 p.m.

13 (Off the record at 5:51 p.m.)

14 (Deposition Exhibits Nos. 1 through 6 marked  
15 and attached.)

16 (Back on the record at 5:54 p.m.)

17 THE VIDEO TECHNICIAN: We're back on the  
18 record at 5:54 p.m.

19 BY MR. TEMROWSKI:

20 Q. Doctor, we've now had marked the MRI reports as  
21 Exhibits 3, 4, 5, and 6.

22 And would you agree with me that in the  
23 case of Mr. Waskowski that Exhibit 3 and 4 which is an  
24 MRI of the cervical spine which is the neck and an MRI  
25 of the lumbar spine which is the back was performed at

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1 a facility called Macomb MRI?

2 A. Correct.

3 Q. And one of Mr. Waskowski's doctors sent him there to  
4 have the MRI done, correct?

5 A. That's correct.

6 Q. And that's who?

7 A. I believe it says referring physician on both of them,  
8 Doctor Glowacki.

9 Q. Okay. And those MRI reports were authored by a  
10 radiologist, correct?

11 A. Correct.

12 Q. And on the second page it's got a Doctor Michele Keys?

13 A. Correct.

14 Q. Okay. And Exhibits 5 and 6 are a different set of  
15 MRIs that were performed at Oakland MRI, correct?

16 A. That's correct.

17 Q. And, again, one of Mr. Waskowski's doctors sent  
18 Mr. Waskowski to that facility to have MRIs done,  
19 correct?

20 ~~MR. HEWSON: Objection, foundation.~~

21 ~~Go ahead.~~

22 THE WITNESS: Correct.

23 BY MR. TEMROWSKI:

24 Q. And what doctor is that?

25 A. That's Doctor Zalmarano.

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1 Q. And, again, those MRIs were authored by a radiologist,  
2 correct?

3 A. That's correct, Doctor Maida.

4 Q. Okay. Now, would you agree with me that in reading  
5 all four of those exhibits over regarding the MRIs at  
6 two different facilities of Mr. Waskowski's neck and  
7 back that those radiologists who prepared and authored  
8 those reports refer to herniated discs?

9 ~~MR HEWSON: I'm going to object as to the~~  
10 ~~compound nature of the question.~~

11 But, Doctor, subject to that, you can  
12 answer.

13 THE WITNESS: Yes. They use the term disc  
14 herniation which is a term commonly used. Yes.

15 BY MR. TEMROWSKI:

16 Q. And when I heard your direct testimony today with  
17 Mr. Hewson here, I only one time actually heard you  
18 use the term herniated disc when you were referring to  
19 one of those reports.

20 A. That's probably true, yes.

21 Q. What I'd like to know, Doctor, about your testimony  
22 here today is are you giving any testimony to this  
23 jury as to your opinion as to whether or not  
24 Mr. Waskowski was injured in the automobile collision  
25 of December 23rd, 2009?

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1 A. No, I am not. I am reviewing imaging studies to see  
2 if I have any evidence for a traumatic event involving  
3 the head, the neck part of the spine, cervical spine,  
4 or the lumbosacral spine.

5 Q. Okay. And you never met Mr. Waskowski?

6 A. That's correct.

7 Q. You never examined him?

8 A. That's correct.

9 Q. If he walked in here today, you won't know who he was?

10 A. I wouldn't know who he was.

11 MR. TEMROWSKI: Thank you. I have nothing  
12 else.

13 MR. HEWSON: Just a couple of follow-up.

14 REEXAMINATION BY MR. HEWSON:

15 Q. Why didn't you use the word herniation?

16 A. Herniation has become a general term in terms of what  
17 it actually means. It encompasses so many different  
18 things that the current terminology for describing  
19 abnormalities in discs has evolved, that the actual  
20 terminology people should be using which has been  
21 written about for the past ten, fifteen years, bulging  
22 discs, protruding discs, extruded discs, sequestered  
23 discs, which are more specific.

24 And sometimes people lump everything into  
25 the term herniation, and it encompasses such a broad

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1 range of what could be present that it really doesn't  
2 tell people anything.

3 Q. Now, do you need to meet the patient in order to  
4 interpret the films, I'm sorry, the images?

5 A. No.

6 Q. My brother counsel marked the April 15th, 2010 MRI of  
7 the lumbar spine as one of the exhibits.

8 Can you tell me just which one, what number  
9 that is?

10 A. Of which date?

11 Q. April 15th, 2010.

12 A. April 15th is Exhibit 4.

13 Q. Is the addendum from Doctor Keys attached to that?

14 A. It is.

15 Q. What was the addendum or the date of the addendum?

16 A. The addendum is dated July 27th, 2010.

17 Q. And what was the addendum or what did it pertain to  
18 according at least to this report?

19 A. Why don't I read it. Regarding the impression that  
20 there are disc herniations at L4-5 and L5-S1, cannot  
21 determine whether or not these are new or old disc  
22 herniations. These are age-indeterminate disc  
23 herniations.

24 So that's referring to the abnormalities  
25 that Doctor Keys identified on the April 15th, 2010

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1 study. She believes there are disc herniations there  
2 but doesn't know how old they are.

3 Q. And your review of the film, well, you've already  
4 explained the herniation issue.

5 Do you agree that there's no way to  
6 determine the age of these findings, whatever  
7 terminology should have been used?

8 A. In general, yes, that that's -- it can be very hard to  
9 date things. We, of course, have chronic degenerative  
10 changes seen in association with these findings which  
11 we see as early as January 4th, 2010 which tells me  
12 the patient's degenerative changes were old at that  
13 time.

14 MR. HEWSON: Very good. Thank you. I have  
15 nothing further.

16 MR. TEMROWSKI: Nothing else.

17 THE VIDEO TECHNICIAN: This concludes the  
18 deposition, and we're going off the record at 6:00  
19 p.m.

20

21 (Deposition concluded at 6:00 p.m.)

22

23

24

25



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1 STATE OF MICHIGAN )  
2 ) SS.  
3 COUNTY OF LIVINGSTON )

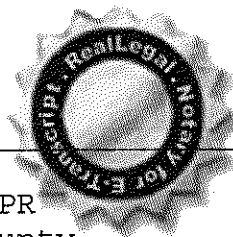
4 CERTIFICATE OF NOTARY PUBLIC

5 I certify that this transcript  
6 is a complete, true, and correct record of the  
7 testimony of the deponent to the best of my ability  
8 taken on Tuesday, November 13, 2012.

9 I also certify that prior to  
10 taking this deposition, the witness was duly sworn by  
11 me to tell the truth.

12 I also certify that I am not a  
13 relative or employee of a party, or a relative or  
14 employee of an attorney for a party, have a contract  
15 with a party, or am financially interested in the  
16 action.

17  
18  
19  
20  
21 Cheryl McDowell



22 Cheryl McDowell, CSR-2662, RPR  
23 Notary Public, Livingston County  
24 State of Michigan  
25 Commission Expires September 13, 2013

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